Discharge Planning

Screening Tool

Risk Colour: Green Yellow Red DC: _____

RN Completed by _____ Date:_____

Addressograph

Living arrangements? (house □ , apartment □, assisted living □, supportive housing □, PCH □, Homeless □)

Y	N	The following 6 questions must be asked on all patients by the admitting nurse.
□	□	**1**-Alert and orientated X3 and appropriate in conversation
□	□	**2**-Free of falls in the last 6 months
□	□	**3**-Was able to mobilize independently with or without gait aid prior to admission
□	□	**4**-Currently managing independently or has supports for: self-care □, toileting □, transfers □, groceries □, cleaning □, laundry □, meal preparation □, medication □, and transportation □
□	□	**5**-Patient and family/support are confident that the patient can be discharged to their current living situation
□	□	**6**-Answers appropriately to "*You wake up in the middle of the night and smell smoke in your home, what do you do?*"

(fill out remaining form if there was a N(o) answer above) Initials

Additional General Information

1. Who are they living with? (alone □, with partner □ , with other family □, in a care facility □) Specify:
2. What are their support systems? (partner □, family □, friend □, community resources □) Specify:
3. Who is the primary contact? _____
4. Does the patient have medications in bubble packs? yes □ no □
5. Prior to admission mobility: Independent □, 1 assist □, 2 assist □, mechanical lift □ Gait aid: none □, cane □, walker □, wheelchair

Physiotherapy

Consult required yes ☐ no ☐ Date: dd/mm/yyyy _____

□ 1. A noted decline from pre admission mobility status (see Safe Patient Handling form)

Occupational Therapy

Consult required yes ☐ no ☐ Date: dd/mm/yyyy _____

□ 1. Patient's functional status has changed
□ 2. Patient's cognition has changed or is impaired
□ 3. Patient is immobile for long periods or is at high risk for developing pressure sores
□ 4. Patient requires a seating assessment
□ 5. Patient requires a splint
□ 6. Facilitation of community follow-up (CTS □, GPAT □, Day Hospital □, PRIME □)
□ 7. Other_____

Social Work

Consult required yes ☐ no ☐ Date: dd/mm/yyyy _____

□ 1. Provide acute support to individual, couple or family
□ 2. Assess and assist with long term care/chronic care placement
□ 3. Assess and assist with suspected physical , sexual, psycho-social or financial abuse
□ 4. Assess and assist patient with procurement of necessary resources
□ 5. Inadequate housing situation
□ 6. Other _____

Home Care

Consult required yes ☐ no ☐ Date: dd/mm/yyyy _____

□ 1. Do they have HC, If so what services? _____
□ 2. Likely to need nursing support for medication administration □, dressing changes □, Other □_____

Notes:_____

_____

_____

_____

Guidelines for Completion of the Discharge Planning Screening Tool

Top section

All patients admitted to a medical ward shall have the top section of this form completed within 24 hours of admission. The first question at the top is about the patient's current living arrangements. It must be filled out in addition to the next 6 questions. If the *Y(es)* column is checked it indicates that the patient is okay; *N(o)* indicates that you are concerned about the patient and feel they will likely need additional support for discharge planning.

Additional explanation:

1. Alert and orientated X3 and appropriate in conversation can only be assessed if the patient is not disorientated due to medication or acute delirium. Indicate if this is an issue.
2. Only use information available in the first 24 hour to answer this question. If after 24 hours Home Care or care givers identify that the patient is having balance or coordination issues do not change the response on the form.
3. This related to the patient's ability to mobilize prior to the concern that resulted in the admission.
4. Please review all functions and place a checkmark beside each function indicating the patient is currently managing. Check the *N(o)*column if the patient is not managing independently or with supports for one or more functions.
5. If the family/support cannot be questioned in the 24 hour window, but the patient is confident and independent of support the answer is *Y(es)*.
6. The appropriate answer to the question 6 is to leave the building and call 911, or awaken other family members, leave the building and call 911. Variations on the answer are acceptable as the purpose is to ensure the patient is able to demonstrate problem solving skills.

If a question is left blank after 24 hours the assumption is that some risk was perceived so the question will be automatically defaulted to N(o) in the risk assessment model.

Bottom section

If the patient answers positively *Y(es),* to all 6 questions they are at a very low risk to have discharge issues, therefore the remainder of the form is <u>not</u> required. Otherwise complete the rest of the form.

The lower section of the screening tool is intended to assist in determining what discharge planning is required and for what purposes. If there is a check beside any of the Physiotherapy, Occupational Therapy, Social Work or Home Care boxes, check the 'yes' "consult required" box enter the consult date; if none, then check 'no'. Initial beside each discipline to indicate who reviewed the risk factors. The Discharge Planning Screening Tool can be used as the consult itself. If the patient already has Home Care, then Home Care should be consulted.

The Notes section can be used to provide additional consultation details.

If a consult is required the *Nurse Discharge Planning Screening Tool* should be photocopied and sent to the appropriate service. The form replaces the need to use any existing allied health consult forms.